EyeCare Associates
Patient Medical History

Last Name: _____ First Name: _____ MI: ____ Birth Date: / /

Patients Medical Doctor: Occupation: SS # Male Female

MEDICAL HISTORY

Do you have any allergies to medications? No / Yes If yes explain.

List all major injuries, surgeries and/or hospitalizations you have had in the past 5 years:

Circle any of the following that you have had: Crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury.

Are you pregnant and/or nursing? No / Yes

Do you wear glasses? No / Yes If yes, how old is your present pair of lenses?

Do you wear contact lenses? No / Yes If yes, how old is your present pair of lenses?

Type of contact lenses: Rigid Soft Extended wear Other Are they comfortable? No / Yes

FAMILY HISTORY *Have your parents, grandparents, siblings been treated for the following conditions:*

Disease/Condition	N	Y	Relationship to you:	Disease/Condition	N	Y	Relationship to you:
Arthritis				Cancer			
Diabetes				High Blood Pressure			
Glaucoma				Heart Disease			
Macular Degeneration				Kidney Disease			
Any Other							

SOCIAL HISTORY *This information is kept strictly confidential. However you may discuss this portion directly with the doctor if you prefer.*

O Yes, I would prefer to discuss my social history information directly with my doctor. (check circle)

Do you drive? No / Yes If yes, do you have visual difficulty when driving? No / Yes

If YES to visual difficulty please describe:

Do you use tobacco products? No / Yes If yes, type / amount / how long:

Do you drink alcohol? No / Yes If yes, type / amount / how long:

Do you use illegal drugs? No / Yes If yes, type / amount / how long:

Have you ever been exposed to or infected with: ○ Gonorrhea ○ Hepatitis ○ HIV ○ Syphilis ○ N/A

REVIEW OF SYSTEMS *Do you currently, or have you ever had any problems in the following areas:*

	N	Y	Provide explanation / medications
Eyes (glaucoma, cataract, retinal disease, etc.)			
Skin (acne, warts, skin cancer, rosacea, etc.)			
Cardiovascular (heart disease, chest pain, irregular heart beat, etc.)			
Endocrine (diabetes, thyroid)			
Gastrointestinal (stomach ulcers, intestinal disease, etc.)			
Musculoskeletal (arthritis, muscle aches, joint pain, swollen joints)			
Neurological (stroke, numbness, weakness, headaches, etc.)			
Respiratory (asthma, emphysema, etc.)			
Ear / Nose / Mouth / Throat (sinus, ear infection, chronic cough, etc.)			
Allergic / Immunologic (hay fever, lupus, HIV, hepatitis)			
Blood / Lymph (cholesterolemia, anemia, etc.)			
Psychiatric (anxiety, depression, insomnia)			

For Office Use Only

Doctor's Signature: _____ Date: ____

Follow-up visits, reviewed and signed:

Doctor's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

OVER

EyeCare Associates

Patient Medical History

(Please Print Clearly)

Today's date:	

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle:	Sex: ❑ M ❑ F	Date of Birth: / /	Social Security # - -
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):			
Email Address:	Home phone no.: ( )	Alternate phone no.: ( )			
Billing Address:	City:	State:	ZIP Code:		

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Person responsible for bill:	Birth date: / /	Address (if different from above):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Employer:	Is this patient covered by insurance?	❑ Yes	❑ No
Name of Primary Insurance		Group #:	Policy #:
Subscriber's name:	Soc. Sec. #: - -	Birth date: / /	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child ❑ Other
Name of secondary Insurance Subscriber's name:		Group #:	Policy #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child ❑ Other
Name of Vision Insurance		Group #:	Policy #:

AUTHORIZATION / FINANCIAL AGREEMENT/ HIPPA

I hereby authorize my examinations, including **dilation** where drops are used to enlarge the pupils in order to get a better view of the inside of my eye. Dilating drops can blur vision for an unspecified length of time and varies from person to person. Some people may require a driver after being dilated.

I authorize payment directly to EyeCare Associates for all benefits payable to me under the terms of the insurance policy for treatment of services provided to me or my dependents. I authorize the release of any medical information necessary to process such insurance claims.

I understand that I am financially responsible for all charges whether or not they are covered by insurance. All prices are an estimate of what the final bill could be.

I am aware of EyeCare Associates 'Notice of Privacy Practices' (HIPPA). Copy available upon request.

_____ _____

Patient/Guardian signature *Date*

EyeCare Associates
Patient Medical History

Patient Name: _____

Medication Name	Dosage	Times per Day